

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00205472.</p> <p>This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on July 7, 2016.</p> <p>Complaint IN00205472 - Substantiated. Federal/State deficiency related to the allegations are cited at F309.</p> <p>Survey date: August 18, 2016</p> <p>Facility number: 000178 Provider number: 155280 AIM number: 100273840</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census payor type: Medicare: 4 Medicaid: 66 Other: 5 Total: 75</p> <p>Sample: 5</p> <p>This deficiency reflects State findings</p>	F 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: August 3, 2016. Facility is respectfully requesting paper compliance for all deficiencies in this POC.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0309 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on August 22, 2016.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to appropriately assess a resident following an unwitnessed fall for 1 of 3 residents reviewed for falls. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's clinical record was reviewed on 08/18/2016 at 2:35 P.M. The resident's Quarterly MDS (Minimum Data Set) assessment, dated 06/29/2016, indicated the resident was severely cognitively impaired with a BIMS (Brief Interview for Mental Status) of 05. The resident's diagnoses included, but were not limited to, hypertension, depression,</p>	F 0309	<p>It is the policy of the facility to ensure that residents are appropriately assessed after any fall. Resident E and all residents have thorough and complete assessments completed post falls.</p> <p>This includes witnessed as well as unwitnessed falls.</p> <p>Unwitnessed falls include neuro checks to be done regardless of the resident's account of the fall or the resident's BIMS score. Note: Resident E did not sustain any injury or negative outcomes related to the fall listed in the 2567 (survey document). Residents who reside in the facility have the potential to be affected by this finding. The falls will be reviewed at the daily CQI</p>	09/05/2016

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	<p>and dementia.</p> <p>Resident #E's "Fall Risk Assessment", dated 07/19/2016, indicated the resident slid out of his/her recliner; but there was no injury. The assessment further indicated the resident had intermittent confusion.</p> <p>The progress note, dated 07/20/2016 at 06:49 A.M., indicated Resident #E was found on the floor in his/her room and "...Denies hitting head."</p> <p>During an interview on 08/18/2016 at 5:03 P.M., the ADON (Assistant Director of Nursing) indicated neurological checks were typically done after an unwitnessed fall. The ADON further indicated neurological checks were not completed for Resident #E following the 07/20/2016 fall because the resident reported he/she did not hit his/her head.</p> <p>During an interview on 08/18/2016 at 6:02 P.M., LPN (Licensed Practical Nurse) #1 indicated neurological checks were completed after every unwitnessed fall, after witnessed falls with a resident observed hitting their head, or if there was any sign the resident had hit their head.</p> <p>The current facility policy, titled "Head</p>		<p>meetings. This will include falls documented in the progress notes, reported to the DON or Administrator or listed on the 24 Hour shift to shift report since the previous CQI meeting. The Falls QA Audit Tool will be used to track falls during the daily CQI meetings. This tool will be used to monitor and track to see that all required assessments, notifications, treatments (as indicated) or any needed interventions as well as care planning, did in fact happen. The use of the tool will be ongoing and updated at the meetings by the DON/Designee.</p> <p>At an in-service held for all staff the following will be reviewed:</p> <p>A.) Fall Prevention Program-Policy & Procedure (Emphasis on post fall care "unwitnessed falls</p> <p style="text-align: right;">to include</p> <p>initiation of neuro checks)</p> <p>B.) What is your role (as a staff member) if you witness a resident fall?</p> <p>C.) Falls Investigation</p> <p>D.) Falls QA Audit Tool</p> <p>E.) Risk Management/Documentation (Nurses)</p> <p>F.) Discussion</p> <p>Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as indicated.</p> <p>At the monthly QA meetings, the</p>	

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	Injuries/Neurological Assessment" and dated 01/27/2013, was provided by the ADON on 08/18/2016 at 5:38 P.M. and was reviewed at that time. The policy indicated, "...Assessments are to be done when it is suspected or known that a resident has had a blow to the head..." 3.1-37(a)		results of the Falls QA Audit Tool results will be reviewed. Any concerns will have been addressed as discovered, however, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.		